RIGHT THE FIRST TIME PROJECT

PERFORMANCE MEASURE	PROJECT	DESCRIPTION	STATUS/OUTCOMES*
1) Reduce by 10% comments that result in claims being suspended.	A) Review all billing instructions to identify all required comments and documents.	8 comments required in all BIs; additional 54 comments required in specific BIs	Eliminated 3 required comments found in all BIs; investigating whether another 2 can be eliminated. Eliminated 13 comments found in specific BIs; investigating whether 10 more can be eliminated. Working with Rules and Publications to disseminate information on discontinued comments. Drafted provider bulletin on effects of sending in unnecessary comments and unsolicited documents. *Outcome: The notification to providers will not occur until later this spring. We expect quantifiable results within six months of release of notification including time for*

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			provider training. Should result in fewer claims suspending because of fewer required comments.
	B) Review representative number of claims to identify what types of comments are being entered on claims	Received over 130,000 line item level comments on non-institutional claims. Reviewed over 30% of the lines. Determined many comments were the same regardless of the type of service billed for; were in "mechanical"/nonreadable formats; and did not provide information that facilitated adjudication.	Discontinued review of additional line item level comments. Used information from survey for provider bulletin on unnecessary comments and unsolicited documents. *Outcome: Provider bulletin will go out later this spring. Quantifiable results should be realized within 6 months of release of provider bulletin including time for provider training. Should result in fewer claims suspending.*
2) Adopt the 11 claims processing administrative simplification policies put forth by the Washington HealthCare Forum	A) Reviewed the policies to determine whether they could be adopted.		Adopted 9 of 11 policies including use of standard coversheets that alert CP staff about transmittal of required documents and re-billed claims. The cover sheets are scannable.

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			Did not adopt policies related to handling injury claims due to federal requirements for TPL and submitting EOB on electronic claims related current MMIS shortcomings. The new system should accept EOBs on electronic claims. *Outcome: MAA's adoption of Forum policies assures we are aligned with other large third party payers which reduces provider/billers' administrative burdens. We assume providers realize savings because of this alignment process; however, we have not been able to quantify the savings. We have been told providers appreciate our efforts to "be like everyone else".*
3) Billing Instructions and text files regarding inpatient hospital services, dental care and Medicare Cross overs are reviewed and revised.			Thorough overhaul of these billing instructions was not possible due to limited resources and other demands on Rules and Publications staff.

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			Rules and Publications staff made changes recommended by RTFT Solutions Team to BIs as they were amended and continue to look for opportunities to make the documents more useable. *Outcome: Per input from billers, they are able to search billing instructions more quickly and easily; thus making them for useful.*
4) Reduce the percentage of claims suspended by 10%.	See project related to reduction of comments and documents.		At any given period about 80,000 claims are in suspend status. With the elimination of a number of required comments, the total number of claims in suspend status may drop. However, factors outside the purview of RTFT such as the CCI project, training activities within CP, or MMIS processing changes can eliminate the results from RFTF administrative simplification efforts.
5) Reduce the percentage of	RTFT Data Committee		After extensive review, ACS,

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re-billed claims by 10%.	developed data request to identify re-billed claims, establish a baseline and collect information to determine whether RTFT efforts affected re-billing activities.		HWT and MAA staff concluded MMIS does not have indicators that would facilitate establishing a baseline or tracking re-billed claims activities. Any data on re-billing would be seriously flawed. The MMIS reprocurement group has taken the request for indicators to establish a baseline and track re-billing claims activities under advisement. *Outcome: Although we were unable to develop a baseline for the number of re-billed claims at this time, we have been told that RTFT efforts resulted in more claims being submitted correctly the first time.* *Providers appreciated activities such as adoption of Forum policies, increased on*

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			line provider communication and education, elimination of the so-called "Out of Balance" denial and reduction in required comments and documents.
6) Reduce the percentage of denied claims by 5% (Focus on the 20 top providers who had a high volume of denied claims)	Data analysis of claims denial activities including information on claims denial experience of mail top 20 providers with high volumes of denied claims. Follow up calls were made by PRU staff to determine whether provider needed on site training.	Following up on the top 20 providers with high volumes of denied claims to determine change in claims submission behavior. Analysis should be completed by mid April.	Denied claims for this purpose include non-institutional claims excluding Medicare cross overs and POS. *Outcome: Overall claim denial for all providers: Baseline: 17% denied at the header level; latest reporting period (12/04) 15.6%.*
7) Pilot, modify and adopt a decision management process that is cross divisional	Develop a model of decision making that could be used by the rest of MAA.		RTFT uses a two-tiered decision making process: A Solutions Team composed of representatives from MAA offer suggestions for administrative simplification efforts, work with colleagues to implement changes and report results. Suggested changes are presented through the decision paper process.

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			The Steering Committee composed of some members of Executive Leadership as well as program managers provides direction and approves simplification efforts that extend across divisions or have costs attached. A data group provide data collection and analysis for the group. *Outcome: Decision paper available on MAA forms website.*
8) Review the number of dental forms we permit dentists to use and reduce the number if necessary			Following the lead of WDS. Although a number of meetings have been cancelled by WDS, expect mid April meeting to be held.
9) Increase provider communications/understanding about MAA.	A) Compiled email list to alert providers about changes in BIs, numbered memoranda, etc. B) Developed and distributed 4 provider bulletins targeted to specific administrative		*Outcome:* *A) Doubled the number of providers receiving information by email.* Will continue to secure more

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	simplification efforts. C) Coordinated with MACSC staff to ensure consistent messages. D) Made improvements to BI Website to make it more usable. E) Through "flash" web surveys recovering feedback on provider training. F) Provided on site training/trouble shooting with hospital staff to determine reason(s) for denied claims including work with Mental Health Division, PRU field unit and RSNs to address outstanding concerns related to inpatient psychiatric billing activities.		email addresses including requesting email addresses from the over 800 participants of the Forum for HealthCare's 7 spring conferences. B) 3 additional provider bulletins are in development including ones on WAMEDWEB, comments and documents and provider numbers. *D) Outcome: Feedback from providers has been positive about changes in BI Website.* *E)Outcome: Provider field unit is tailoring training efforts based on feedback results such as more basic trainings for less experienced billers and more targeted training for those more experienced.* *BI flash surveys will begin later this spring.*

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			Plan to use flash survey to determine usefulness of provider bulletins. Expect survey to be carried out in late spring. *F) Outcome: Results of on site training result in greater understanding on how to bill correctly for these complex claims. We expect to see positive results in the next three months' billing activities and will track both Valley General's and St. Peter's Hospital inpatient psychiatric billing.*

*** Status/Outcomes**: Provide information on accomplishments, whether the effort is ongoing, and results. Please note that in a number of cases, quantifiable data were not available and results are anecdotal in nature. However, this does not diminish their worth. A final report on RTFT activities including recommendations for further efforts will be completed before June 30, 2005.

Other activities that have affected RTFT:

1) Terminated Return to Provider efforts on March 1.

"Unscannable" paper claims are no longer returned to the provider prior to adjudication, but are treated like any other paper claim with denial information on the RAs. May result in more paper claims being denied. Data collection and analysis will focus on the number of paper claims denied because information is not "scannable".

2) Require provider enrollment numbers for attending, performing, referring providers effective April 1.

May increase the number of denied claims. Data to analyze effects of this policy change include:
1) number of provider calls related to questions about policy change,
2) number of provider calls requesting MACSC staff help to identify provider numbers,
3) number of providers who request termination of core provider numbers due to policy change,
4) by claim type and provider/biller, number of denied claims because of failure to enter provider numbers, and
5) by claim type and provider/biller number of instances when the standard provider number for non-Medicaid referring provider is entered on claims.